

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7834

07820

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CALVERT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HUNTINGTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>116 JEFFERSON ST NW</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH FRANK ALLEN</u>		4. DATE OF DEATH Month Day Year <u>JULY 3 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 15 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAVAL GUN FACTORY</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASH D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS F. ALLEN</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>MRS MARY E ALLEN HUNTINGTOWN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 19 58</u> to <u>JULY 3 1960</u> , that I last saw the deceased alive on <u>MAY 12 1960</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D.		DATE SIGNED <u>7/4/60</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		<u>PRINCE FREDERICK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-7-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mattingly</u> ADDRESS <u>131-11 S.E. Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and signature of the attending physician. The form is divided into several horizontal sections with labels for each field.

RECEIVED

Vertical text on the right margin, likely a date stamp or filing information, including the words "RECEIVED" and "FILED".



MARYLAND STATE DEPARTMENT OF HEALTH & HIGHER EDUCATION  
Baltimore, Md.  
1932

1932

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

HEIGHT

WEIGHT

HAIR

EYES

SKIN

TEETH

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VOICE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07822

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: full name before admission) a. STATE <u>Md</u> b. COUNTY <u>PF</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> d. STREET ADDRESS <u>16X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>McDonald</u> Middle <u>Estes</u> Last 4. DATE OF DEATH <u>7</u> Month <u>8</u> Day <u>1960</u> Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Apr 24, 1935</u> 9. AGE (in years last birthday) <u>25</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Freem. Co</u> 11. BIRTHPLACE (State or foreign country) <u>MO</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>James Les Estes</u> 14. MOTHER'S MAIDEN NAME <u>Mary Joye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>217-32-3826</u> 17. INFORMANT <u>James Estes, Crownsville</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun</u> DUE TO <u>Suicide</u> Conditions, if any, which gave rise to immediate cause (b) <u>Suicide</u> (c) <u>Suicide</u> DUE TO <u>Suicide</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had killed a colored girl 7/8/60</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Injured by R. R. Bridge</u> 20c. TIME OF INJURY Month, Day, Year <u>7-8-60</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, hotel, office, etc.) <u>R.R. Bridge</u> 20f. (City or town) <u>PF</u> (County) <u>Calvert</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u> EXAMINER'S NAME (Type) <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-12-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u> 22d. LOCATION (City, town, or county) (State) <u>15aafstown Charles Md</u>		24a. REC'D BY REGISTRAR <u>Jul 14 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Go. S. Nelson</u> ADDRESS <u>1348 N. Calhoun St</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF OTHERS		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF SURVIVORS		23. SIGNATURE OF NEAR RELATIVES		24. SIGNATURE OF FRIENDS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF OTHERS		41. SIGNATURE OF OTHERS		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF OTHERS		80. SIGNATURE OF OTHERS		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF OTHERS		83. SIGNATURE OF OTHERS		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF OTHERS		86. SIGNATURE OF OTHERS		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF OTHERS		89. SIGNATURE OF OTHERS		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF OTHERS		92. SIGNATURE OF OTHERS		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF OTHERS		95. SIGNATURE OF OTHERS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7837

## CERTIFICATE OF DEATH

07823

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Calvert</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Fredericktown</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Fredericktown</i>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Chief Cunningham Hamner</i>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>7 12 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>Nov 21, 1871</i>
		9. AGE last birthday <i>88</i> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>W. Va</i>
13. FATHER'S NAME <i>Long Hamner</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i> <i>1890-1920</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT & ADDRESS <i>Carl Hamner</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <i>442x Cardiovascular-renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Had a virus infection</i>		<i>6 days</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> No while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>July 12, 1960</i> to <i>July 12, 1960</i> , that I last saw the deceased alive on <i>July 12, 1960</i> , and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>H.W. Ward</i>		DATE SIGNED <i>July 12, 1960</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal - Burial</i>		DATE THEREOF <i>July 13, 1960</i>	
NAME OF CEMETERY OR CREMATORY <i>Frame Family Lot</i>		LOCATION (City, town, or county) (State) <i>Passaway - W. Virginia</i>	
24. REC'D BY REGISTRAR <i>JUL 15 '60</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>A.G. Harkness &amp; Son - Mutual, Ind.</i>	
REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		ADDRESS	
DATE			

# CERTIFICATE OF DEATH

1952

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF CONSTABLE

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF CLERK

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY SHERIFF

30. SIGNATURE OF CONSTABLE

31. SIGNATURE OF JURY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY SHERIFF

36. SIGNATURE OF CONSTABLE

37. SIGNATURE OF JURY

38. SIGNATURE OF JUDGE

39. SIGNATURE OF CLERK

39. SIGNATURE OF SHERIFF

40. SIGNATURE OF DEPUTY SHERIFF

40. SIGNATURE OF CONSTABLE

41. SIGNATURE OF JURY

41. SIGNATURE OF JUDGE

42. SIGNATURE OF CLERK

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF DEPUTY SHERIFF

43. SIGNATURE OF CONSTABLE

44. SIGNATURE OF JURY

44. SIGNATURE OF JUDGE

45. SIGNATURE OF CLERK

45. SIGNATURE OF SHERIFF

46. SIGNATURE OF DEPUTY SHERIFF

46. SIGNATURE OF CONSTABLE

47. SIGNATURE OF JURY

47. SIGNATURE OF JUDGE

48. SIGNATURE OF CLERK

48. SIGNATURE OF SHERIFF

49. SIGNATURE OF DEPUTY SHERIFF

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51. SIGNATURE OF CLERK

51. SIGNATURE OF SHERIFF

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53. SIGNATURE OF JURY

53. SIGNATURE OF JUDGE

54. SIGNATURE OF CLERK

54. SIGNATURE OF SHERIFF

55. SIGNATURE OF DEPUTY SHERIFF

55. SIGNATURE OF CONSTABLE

56. SIGNATURE OF JURY

56. SIGNATURE OF JUDGE

57. SIGNATURE OF CLERK



7838

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Washington</u> Middle <u>J.</u> Last <u>Hance</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 17, 1876</u>	9. AGE <u>84</u> years (lost birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Calvert Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Tommy Hance</u>				14. MOTHER'S MAIDEN NAME <u>James Rebecca Sedwick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Lloyd Hance, Prince Frederick Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>332X</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arterial sclerosis</u> DUE TO (c) <u>Cerebral arterial sclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>July 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>60</u> , and that death occurred at <u>7:28 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Hance</u> M.D.				ADDRESS (Street, city or town, state) <u>57 Hannon St.</u>			
DATE SIGNED <u>7/28</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 29, 1960</u>		<u>Asbury Cemetery</u>		<u>Harrods Calvert Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. W. Hance</u>				ADDRESS <u>504 National, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hance</u>	
DATE <u>AUG 2 '60</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1888

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE, MARYLAND		JANUARY 1, 1888	
SEX		AGE	
MALE		21 YEARS	
RACE		COLOR	
WHITE		WHITE	
RELIGION		EDUCATION	
METHODIST		SCHOOL GRADUATE	
MARRIED		SINGLE	
WIDOW		DIVORCED	
MILITARY SERVICE		NATIONALITY	
NONE		AMERICAN	
PREVIOUS ILLNESS		CAUSE OF DEATH	
NONE		DIPHTHERIA	
DATE OF DEATH		PLACE OF DEATH	
JANUARY 15, 1888		BALTIMORE, MARYLAND	
HOURS OF DEATH		MANNER OF DEATH	
10:00 AM		NATURAL CAUSE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. B. [illegible]		[illegible]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 16, 1888		JANUARY 16, 1888	

7839

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olriet</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James E. Joy</u>		4. DATE OF DEATH <u>July 25 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 11, 1874</u>
9. AGE (In years last birthday) <u>86</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabret Co., Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James E. Joy</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-8401</u>	
17. INFORMANT <u>Delma Joy - Olriet, Ind.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>60</u> , to <u>7/25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/13</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>PAUL C. JETT</u>		DATE SIGNED <u>7-26/60</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C. JETT</u>		ADDRESS (Street, city or town, state) <u>PRINCE FREDERICK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 28, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Olriet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cabret Co. - Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Walker &amp; Son - Mutual, Ind.</u>		24. REC'D BY REGISTRAR <u>JUL 28 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

FILE NO.

DATE OF DEATH

DECEASED

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

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PLACE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7840

## CERTIFICATE OF DEATH

Reg. Dist. No. 07826

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eda Jane Knapp</u> First Middle Last		4. DATE OF DEATH <u>7/2</u> Month Day Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Natthew, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George F. Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Sara J. Choney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MRS LIND PARKS DEDLE, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> DUE TO <u>Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28</u> to <u>July 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>60</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7/2/60</u> DATE SIGNED	
ACTUAL SIGNATURE <u>H W Ward</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Owens, Wd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>LOTITIAN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Beltsville Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Proulx</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7841

## CERTIFICATE OF DEATH

Reg. Dist. 47822

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>			
				d. STREET ADDRESS <u>08X-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Matthews</u>				4. DATE OF DEATH Month Day Year <u>July 11 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>UNK — 1879</u>	
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>James F. Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Brent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-03-7250</u>		17. INFORMANT <u>LAURA MATTHEWS, LA PLATA, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular renal disease due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>diabetes</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>60</u> , to <u>July 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>60</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Maryland</u> DATE SIGNED <u>7/12/60</u>							
ACTUAL SIGNATURE <u>George J. Weems, M. D.</u>				PHYSICIAN'S NAME (Type) <u>George J. Weems, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				ADDRESS <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 15 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert S. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7842-

## CERTIFICATE OF DEATH

Reg. Dist. No.

07828

1. PLACE OF DEATH o. COUNTY <i>Cabot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ind</i> b. COUNTY <i>Cabot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 hr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabot County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ETHEL</i> Middle <i>MCCREARY</i> Last <i>MCCREARY</i>		4. DATE OF DEATH Month <i>July</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 15, 1906</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Cabot Co., Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Edward Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Ellie Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Mrs. Yerna Ewing - Chert, Ind</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 14, 1960</i> , to <i>July 14, 1960</i> , that I last saw the deceased alive on <i>July 14, 1960</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Page C. Jett</i>		M.D. <i>Prince Frederick</i>	
PHYSICIAN'S NAME (Type) <i>Page C. Jett</i>		<i>Prince Frederick</i> <i>MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 16, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chert Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Chert - Cabot Co - Ind</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Thacker</i>		ADDRESS <i>4 Son - Mutual, Ind</i>	
24a. REC'D BY REGISTRAR <i>JUL 19 60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of medical examiner		19. Signature of pathologist		20. Signature of anatomist	
21. Signature of coroner		22. Signature of jury		23. Signature of witnesses		24. Signature of funeral director	
25. Signature of undertaker		26. Signature of cemetery		27. Signature of burial place		28. Signature of health officer	
29. Signature of medical examiner		30. Signature of pathologist		31. Signature of anatomist		32. Signature of coroner	
33. Signature of jury		34. Signature of witnesses		35. Signature of funeral director		36. Signature of undertaker	
37. Signature of cemetery		38. Signature of burial place		39. Signature of health officer		40. Signature of medical examiner	
41. Signature of pathologist		42. Signature of anatomist		43. Signature of coroner		44. Signature of jury	
45. Signature of witnesses		46. Signature of funeral director		47. Signature of undertaker		48. Signature of cemetery	
49. Signature of burial place		50. Signature of health officer		51. Signature of medical examiner		52. Signature of pathologist	
53. Signature of anatomist		54. Signature of coroner		55. Signature of jury		56. Signature of witnesses	
57. Signature of funeral director		58. Signature of undertaker		59. Signature of cemetery		60. Signature of burial place	
61. Signature of health officer		62. Signature of medical examiner		63. Signature of pathologist		64. Signature of anatomist	
65. Signature of coroner		66. Signature of jury		67. Signature of witnesses		68. Signature of funeral director	
69. Signature of undertaker		70. Signature of cemetery		71. Signature of burial place		72. Signature of health officer	
73. Signature of medical examiner		74. Signature of pathologist		75. Signature of anatomist		76. Signature of coroner	
77. Signature of jury		78. Signature of witnesses		79. Signature of funeral director		80. Signature of undertaker	
81. Signature of cemetery		82. Signature of burial place		83. Signature of health officer		84. Signature of medical examiner	
85. Signature of pathologist		86. Signature of anatomist		87. Signature of coroner		88. Signature of jury	
89. Signature of witnesses		90. Signature of funeral director		91. Signature of undertaker		92. Signature of cemetery	
93. Signature of burial place		94. Signature of health officer		95. Signature of medical examiner		96. Signature of pathologist	
97. Signature of anatomist		98. Signature of coroner		99. Signature of jury		100. Signature of witnesses	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

7843 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07829

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Paris</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Paris</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Dorcas Evelyn Randall</i>		4. DATE OF DEATH Month Day Year <i>7 8 1960</i>	
5. SEX <i>7</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 9, 1880</i>
9. AGE (In years) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H W</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard Cook</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Moreland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Eda Randall Owens</i>	
17. INFORMANT <i>Eda Randall Owens</i>		Address <i>100</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Renal disease</i> DUE TO (b) <i>Age</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been sick with out medical care</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H W Ward</i>		DATE SIGNED <i>7/8/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>7-11-60</i>		22b. DATE THEREOF <i>7-11-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cortona</i>		22d. LOCATION (City, town, or county) (State) <i>Friendship, A.A. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell, Prince Frederick</i>		ADDRESS <i>Prince Frederick</i>	
24a. REC'D BY REGISTRAR <i>JUL 13 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knecht</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07830  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co. Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ethel Bernad Smith</i> First Middle Last		4. DATE OF DEATH <i>7</i> Month <i>16</i> Day Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/16/1941</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Ethel Smith</i>		14. MOTHER'S MAIDEN NAME <i>Marion Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>218-387176</i>	
17. INFORMANT <i>Alice Smith, Chesapeake Beach</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broken neck</i> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Thrown from car</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Thrown from car</i>	
20c. TIME OF INJURY Month, Day, Year <i>7/15/60</i> Hour <i>1:30</i> .p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway 2</i>	20f. (City or town) <i>Prince Frederick</i> (County) <i>md</i> (State)
21. I certify that I attended the deceased from <i>7/15/60</i> to <i>7/16/60</i> , that I last saw the deceased alive on <i>7/15/60</i> , and that death occurred at <i>12:10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H.W. Ward</i>		ADDRESS (Street, city or town, state) <i>P.O. Box 100, Ocean View, Md.</i>	
PHYSICIAN'S NAME (Type) <i>P.E. Sewell</i>		DATE SIGNED <i>7/16/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>7-19-60</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>St. Edmunds</i>	22d. LOCATION (City, town, or county) <i>Sunderland, Md.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell</i>		ADDRESS <i>Prince Frederick</i>	
24a. REC'D BY REGISTRAR <i>DATE JUL 21 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. BIRTH COUNTRY		8. MARRIAGE DATE		9. MARRIAGE PLACE		10. MARRIAGE COUNTRY	
11. OCCUPATION		12. EDUCATION		13. RELIGION		14. POLITICAL PARTY		15. SOCIAL CLASS		16. MARITAL STATUS		17. NUMBER OF CHILDREN		18. DATE OF DEATH		19. TIME OF DEATH		20. PLACE OF DEATH	
21. CAUSE OF DEATH		22. DISEASE		23. SYMPTOMS		24. TREATMENT		25. MEDICAL HISTORY		26. PREVIOUS ILLNESS		27. PREVIOUS SURGERY		28. PREVIOUS TRAUMA		29. PREVIOUS ACCIDENT		30. PREVIOUS DRUGS	
31. PREVIOUS ALCOHOL		32. PREVIOUS TOBACCO		33. PREVIOUS DRUGS		34. PREVIOUS TRAUMA		35. PREVIOUS ACCIDENT		36. PREVIOUS DRUGS		37. PREVIOUS TRAUMA		38. PREVIOUS ACCIDENT		39. PREVIOUS DRUGS		40. PREVIOUS TRAUMA	
41. PREVIOUS ACCIDENT		42. PREVIOUS DRUGS		43. PREVIOUS TRAUMA		44. PREVIOUS ACCIDENT		45. PREVIOUS DRUGS		46. PREVIOUS TRAUMA		47. PREVIOUS ACCIDENT		48. PREVIOUS DRUGS		49. PREVIOUS TRAUMA		50. PREVIOUS ACCIDENT	
51. PREVIOUS DRUGS		52. PREVIOUS TRAUMA		53. PREVIOUS ACCIDENT		54. PREVIOUS DRUGS		55. PREVIOUS TRAUMA		56. PREVIOUS ACCIDENT		57. PREVIOUS DRUGS		58. PREVIOUS TRAUMA		59. PREVIOUS ACCIDENT		60. PREVIOUS DRUGS	
61. PREVIOUS TRAUMA		62. PREVIOUS ACCIDENT		63. PREVIOUS DRUGS		64. PREVIOUS TRAUMA		65. PREVIOUS ACCIDENT		66. PREVIOUS DRUGS		67. PREVIOUS TRAUMA		68. PREVIOUS ACCIDENT		69. PREVIOUS DRUGS		70. PREVIOUS TRAUMA	
71. PREVIOUS ACCIDENT		72. PREVIOUS DRUGS		73. PREVIOUS TRAUMA		74. PREVIOUS ACCIDENT		75. PREVIOUS DRUGS		76. PREVIOUS TRAUMA		77. PREVIOUS ACCIDENT		78. PREVIOUS DRUGS		79. PREVIOUS TRAUMA		80. PREVIOUS ACCIDENT	
81. PREVIOUS DRUGS		82. PREVIOUS TRAUMA		83. PREVIOUS ACCIDENT		84. PREVIOUS DRUGS		85. PREVIOUS TRAUMA		86. PREVIOUS ACCIDENT		87. PREVIOUS DRUGS		88. PREVIOUS TRAUMA		89. PREVIOUS ACCIDENT		90. PREVIOUS DRUGS	
91. PREVIOUS TRAUMA		92. PREVIOUS ACCIDENT		93. PREVIOUS DRUGS		94. PREVIOUS TRAUMA		95. PREVIOUS ACCIDENT		96. PREVIOUS DRUGS		97. PREVIOUS TRAUMA		98. PREVIOUS ACCIDENT		99. PREVIOUS DRUGS		100. PREVIOUS TRAUMA	

1. NAME OF DECEASED  
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3. AGE  
4. RACE  
5. BIRTH DATE  
6. BIRTH PLACE  
7. BIRTH COUNTRY  
8. MARRIAGE DATE  
9. MARRIAGE PLACE  
10. MARRIAGE COUNTRY  
11. OCCUPATION  
12. EDUCATION  
13. RELIGION  
14. POLITICAL PARTY  
15. SOCIAL CLASS  
16. MARITAL STATUS  
17. NUMBER OF CHILDREN  
18. DATE OF DEATH  
19. TIME OF DEATH  
20. PLACE OF DEATH  
21. CAUSE OF DEATH  
22. DISEASE  
23. SYMPTOMS  
24. TREATMENT  
25. MEDICAL HISTORY  
26. PREVIOUS ILLNESS  
27. PREVIOUS SURGERY  
28. PREVIOUS TRAUMA  
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98. PREVIOUS ACCIDENT  
99. PREVIOUS DRUGS  
100. PREVIOUS TRAUMA

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

7845

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>N. Beach</u>	
3. NAME OF DECEASED (Type or print) <u>Chester L. R. Weaver</u>		4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/14</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>	
11. BIRTHPLACE (State or foreign country) <u>New Market, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 1942-1945</u>		16. SOCIAL SECURITY NO. <u>265-10-9794</u>	
17. INFORMANT <u>Mrs. Chester Weaver</u>		Address <u>North Beach</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot wound of chest</u> DUE TO (b) <u>bullet</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Found dead in chair</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in chair</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted</u>	
20c. TIME OF INJURY Month, Day, Year <u>7 9 1960</u> Hour <u>5</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) <u>Home</u>		20f. City or town <u>N. Beach</u> (County) <u>Calvert</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cem</u>		22d. LOCATION (City, town, or county) <u>New Market</u> (State) <u>Ta.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hatchling Funeral Home (Overland)</u>		24a. REC'D BY REGISTRAR <u>Jul 13 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kious</u>	

DATE SIGNED

7/9/60



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint handwritten text]

2. SEX: [Faint handwritten text]

3. AGE: [Faint handwritten text]

4. OCCUPATION: [Faint handwritten text]

5. PLACE OF BIRTH: [Faint handwritten text]

6. DATE OF BIRTH: [Faint handwritten text]

7. DATE OF DEATH: [Faint handwritten text]

8. TIME OF DEATH: [Faint handwritten text]

9. PLACE OF DEATH: [Faint handwritten text]

10. CAUSE OF DEATH: [Faint handwritten text]

11. MANNER OF DEATH: [Faint handwritten text]

12. SIGNATURE OF MEDICAL EXAMINER: [Faint handwritten signature]

13. DATE OF SIGNATURE: [Faint handwritten text]

14. ADDRESS OF MEDICAL EXAMINER: [Faint handwritten text]

15. CITY: [Faint handwritten text]

16. STATE: [Faint handwritten text]

17. ZIP CODE: [Faint handwritten text]

18. COUNTY: [Faint handwritten text]

19. DISTRICT: [Faint handwritten text]

20. WARD: [Faint handwritten text]

21. BLOCK: [Faint handwritten text]

22. LOT: [Faint handwritten text]

23. PARCEL: [Faint handwritten text]

24. SECTION: [Faint handwritten text]

25. TOWNSHIP: [Faint handwritten text]

26. RANGE: [Faint handwritten text]

27. MERIDIAN: [Faint handwritten text]

28. CORNER: [Faint handwritten text]

29. BEARING: [Faint handwritten text]

30. DISTANCE: [Faint handwritten text]

31. AREA: [Faint handwritten text]

32. VOLUME: [Faint handwritten text]

33. PAGE: [Faint handwritten text]

34. BOOK: [Faint handwritten text]

35. SHEET: [Faint handwritten text]

36. MAP: [Faint handwritten text]

37. PLAN: [Faint handwritten text]

38. SPECIFICATION: [Faint handwritten text]

39. DESCRIPTION: [Faint handwritten text]

40. NOTES: [Faint handwritten text]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7846

## CERTIFICATE OF DEATH

07832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aquasco</u> 16X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>maude</u> Middle <u>S.</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 1881</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Selby</u>				14. MOTHER'S MAIDEN NAME <u>Frances Bayne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-6591</u>		17. INFORMANT <u>Walter S. Young, Aquasco, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V. Disease</u> DUE TO (c) <u>Chronic Arteriosclerosis (Pellagra)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>60</u> , to <u>7/27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page Jett</u>				ADDRESS (Street, city or town, state) <u>Prince Frederick</u>		DATE SIGNED <u>7/28/60</u>	
PHYSICIAN'S NAME (Type) <u>PAGE O. JETT</u>				<u>PRINCE FREDERICK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Aquasco, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

